Washington
State
Hospital
Association

April 15, 2013

*Submitted electronically*

The Honorable Co-Chairs Dave Reichert and John Lewis
Ways and Means Committee Office
1102 Longworth House Office Building
Washington, D.C. 20515

***Re: Charitable/Exempt Organizations Work Group***

Dear Representatives Reichert and Lewis,

Thank you for taking the time to learn more about the work hospitals and health systems in Washington State are doing to ensure our communities have access to the high quality health care they need. This letter is in response to the proposal to create a federal minimum charity care standard. We oppose this proposal; we believe it would be an ineffective measure given the changes coming through the Affordable Care Act, the variability of health care needs among different communities, and the need for hospitals to creatively serve those health needs.

***Hospitals are committed to serving their communities.*** Hospitals and health systems are committed to serving their communities and to providing safe, high quality, effective health care. Hospitals fulfill this mission in a variety of ways, from preventing illness through screenings, education, and vaccination programs, to heavily subsidizing services such as crisis intervention and providing access to free care in times of injury or illness. The good works provided by hospitals, of which charity care is one piece, all fall under the umbrella of community benefit. Community benefit is defined by the Internal Revenue Service as Medicaid and Medicare shortfall, community benefit programs and services, and charity care.

The Washington State Hospital Association estimates the value of community benefit programs and services provided by hospitals/health systems across Washington State was nearly ***$2 billion*** in 2010, including:

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- Charity care (the cost of providing care to the uninsured or under insured): ***$900 million***
- Medicaid shortfall (the difference between cost of care and payment): ***$700 million***
- Community benefit programs and services: ***$300 million***

***Charity care is an overly narrow measurement.*** Charity care alone is a too narrow measurement of the contributions health care organizations make to their communities. Defining a minimum standard based upon only one component of community benefit would not adequately reflect the proportion of the organization's finances being reinvested in the community.

***Charity care is changing with health insurance expansions.*** Hospitals consented to significant Medicare payment and Disproportionate Share Hospital cuts to finance the health coverage expansions contained in the Affordable Care Act. Charity care is not a good way to get health care. It typically covers only acute hospital care, with uninsured patients unable to connect with a community provider for primary care, care management, prescription medications, rehabilitation care, and other services. It is central to hospitals' missions that more people have access to insurance and a full range of health services – not just care in times of crisis. With implementation of the Affordable Care Act, hospitals will provide less charity care as more people become insured – and this is a good thing. In Washington State alone, hospitals will absorb more than $3 billion in payment cuts over the next 10 years to help finance these health coverage expansions.

***Community benefit allows more flexibility.*** A hospital's/health system's community benefits are reported to the IRS through form 990, which allows these organizations to report health investments in their communities. The Affordable Care Act requires 501(c)(3) hospitals to conduct a community health needs assessment and a create a plan to address the identified needs. This needs assessment requirement recognizes that hospitals need to identify community needs *beyond* charity care. A charity care standard could hamper a hospital's ability to respond to the unique needs of their community. For example, some communities may have high levels of insured people who do not need charity care, but who would benefit from programs on how to manage their diabetes and how to prevent it in their children.

***Medicaid and Medicare shortfalls are significant.*** Further, a simple charity care standard does not give hospitals credit for serving large numbers of Medicaid and Medicare enrollees. For most hospitals, Medicare and Medicaid payments do not cover the cost of care delivery. The ACA greatly expands the Medicaid program (which hospitals support). A simple charity care standard does not recognize the benefit serving these populations provides to the community.

***Healthy margins are necessary.*** Comparing charity care percentages to operating margins highlights a misunderstanding of how margins are used in hospitals and why they are needed. To continue serving their communities, hospitals and health systems must operate a sustainable business that allows for reinvestment in their organizations to better serve patients. This includes investments in facilities and equipment that enable care delivery, electronic health records, and the latest infection control and patient safety practices and technologies.

There are several other factors to consider when thinking about hospital and health system margins.

- **Emergency response**. Healthy margins allow hospitals to have reserves to respond to unforeseen events requiring immediate funding. A good example was the H1N1 influenza epidemic. Hospitals needed to use financial reserves to accommodate a surge in the number of patients treated.

- **Bond ratings.** Financial rating agencies, such as Moody's and Standard & Poor's, closely examine margins to determine a hospital's/health system's financial health. As a result, a clear association exists between a healthy margin and a bond rating that allows hospitals/health systems to obtain financing for major projects. Low margins can result in a downward spiral leading to a lower bond rating, creating more difficulty and expense in financing new and replacement capital projects.

- **Incomplete information.** Hospital margins may not reflect the complete range of services provided by the health care system. Systems often use margins generated from their inpatient and outpatient hospital services to support other parts of their delivery system. These services may

include physician services, home health, or hospice – which are not reflected in the reports they file with the state. This may give the appearance that hospital system margins are higher than they actually are.

At face value, requiring hospitals and health systems to provide a percentage of charity care relative to their operating margin seems like a simple way to ensure communities are getting the benefit they deserve. In reality, however, this simplistic approach does not provide the flexibility needed to meet the needs of the community or account for the reinvestment of hospital margins into enhanced services for the community.

In contrast, the current community benefits standard offers a comprehensive approach that works well for communities across the nation. Moving to a minimum charity care standard would be a step backward in policy under the Affordable Care Act. We hope you will join us in opposing this policy.

If you have any questions, please contact Chelene Whiteaker at [redacted].

Sincerely,

Chelene Whiteaker

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cc: Representative Reichert's Office Staff
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